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	013112	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION IN HOME HEALTH CARE, LLC	190 W BECKS MILL ROAD STE F SALEM, IN 47167

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G 000	INITIAL COMMENTS This visit was a Home Health Initial Medicaid certification survey. This was a partial extended survey. Survey Dates: August 21 - 23, 2013 Partial Extended Survey Date: August 22, 2013 Facility Number: 013112 Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor Census Service Type: Skilled: 10 Home Health Aide Only: 7 Personal Care Only: 0 Total: 17 Sample: RR w/HV: 2 RR w/o HV: 8 Total: 10 Quality Review: Joyce Elder, MSN, BSN, RN August 29, 2013 This survey was modified as the result of an internal IDR 10/9/13. je	G 000		
G 102	484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.	G 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 102	Continued From page 1	G 102		

This STANDARD is not met as evidenced by:
Based on clinical record review and interview, the home health agency failed to provide patients with the OASIS Privacy Notice in advance of furnishing care to the patient in 10 of 10 records reviewed with the potential to affect all patients who receive care. (#1, #2, #3, #4, #5, #6, #7, #8, #9, and #10)

The findings include:

1. Clinical record #1, start of care 3/26/13, did not contain documentation the patient had received the OASIS Privacy Notice.

2. Clinical record #2, start of care 6/7/13, did not contain documentation the patient had received the OASIS Privacy Notice.

3. Clinical record #3, start of care 3/26/13, did not contain documentation the patient had received the OASIS Privacy Notice.

4. Clinical record #4, start of care 5/30/13, did not contain documentation the patient had received the OASIS Privacy Notice.

5. Clinical record #5, start of care 6/7/13, did not contain documentation the patient had received the OASIS Privacy Notice.

6. Clinical record #6, start of care 5/13/13, did not contain documentation the patient had received the OASIS Privacy Notice.

7. Clinical record #7, start of care 3/26/13, did not contain documentation the patient had

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G 102	Continued From page 2 received the OASIS Privacy Notice. 8. Clinical record #8, start of care 5/8/13, did not contain documentation the patient had received the OASIS Privacy Notice. 9. Clinical record #9, start of care 5/17/13, did not contain documentation the patient had received the OASIS Privacy Notice. 10. Clinical record #10, start of care 3/28/13, did not contain documentation the patient had received the OASIS Privacy Notice. 11. During an interview on 8/23/13 at 8:10 PM, employee K, Alternate Administrator, indicated the admission packet contained a similar document to the OASIS Privacy Notice, but the clinical charts did not contain the OASIS Privacy Notice document.	G 102		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	G 116		

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G 116	Continued From page 3 This STANDARD is not met as evidenced by: Based on admission packet and clinical record review and interview, the agency failed to ensure patients were given the correct Indiana State Department of Health (ISDH) complaint hotline number for 2 of 10 records reviewed (#1 and #2) with the potential to affect all patients receiving services. The findings include: 1. The admission packet states,"Phone: 1-800-246-8909. [Long Term Care number] Please include your name, address, and phone number when writing or emailing. You may send written complaints to: Indiana State Department of Health Division of Long Term Care." The document provided to patients failed to evidence the ISDH Acute Care complaint hotline number, 1-800-227-6334. 2. Clinical records 1-2 evidenced the patient had received the admission packet with the incorrect hotline number. 3. During an interview on 8/22/13 at 5:05 PM, employee K, Alternate Administrator, indicated they were unaware of the Home Health Agency hotline.	G 116		
G 204	484.36(a)(1) HHA TRAINING - CONTENT & DURATION The aide training program must address each of the following subject areas through classroom and supervised practical training totalling at least 75 hours, with at least 16 hours devoted to supervised practical training.	G 204		

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G 204	Continued From page 4 This STANDARD is not met as evidenced by: Based on the agency's Home Health Aide (HHA) training program review and interview, the agency failed to record the required classroom and supervised practical training totaling at least 75 hours with at least 16 hours devoted to supervised practical training with the potential to affect all the patients of the agency receiving aide services. Findings include: 1. Review of the HHA Training program failed to evidence a record of hours for classroom and practical training for the HHAs. 2. On 8/21/13 at 5:07 PM, employee K, Alternate Administrator, indicated the agency did not have a tracking system in place for recording the HHA training program hours.	G 204		
G 205	484.36(a)(1) HHA TRAINING - CONTENT & DURATION The individual aide being trained must complete at least 16 hours of classroom training before beginning the supervised practical training. This STANDARD is not met as evidenced by: Based on the agency's Home Health Aide (HHA) training program review and interview, the agency failed to ensure the individual aide being trained completed at least 16 hours of classroom training before beginning the supervised practical training with the potential to affect all the patients of the	G 205		

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G 205	Continued From page 5 agency receiving aide services. Findings include: 1. Review of the HHA Training program failed to evidence a record of the HHA completing at least 16 hours of classroom training before beginning the supervised practical training. 2. On 8/21/13 at 5:08 PM, employee K, Alternate Administrator, indicated the agency did not have a tracking system in place for recording the classroom portion of the HHA training program hours.	G 205		
G 206	484.36(a)(1) HHA TRAINING - CONTENT AND DURATION The home health aide must complete training in: - Communications skills. - Observation, reporting and documentation of patient status and the care or service furnished. - Reading and recording temperature, pulse, and respiration. - Basic infection control procedures. - Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. - Maintenance of a clean, safe, and healthy environment. - Recognizing emergencies and knowledge of emergency procedures. - The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy and his or her property. Appropriate and safe techniques in personal	G 206		

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G 206	Continued From page 6 hygiene and grooming that include-- - Bed bath. - Sponge, tub, or shower bath. - Shampoo, sink, tub, or bed. - Nail and skin care. - Oral hygiene. - Toileting and elimination. - Safe transfer techniques and ambulation. - Normal range of motion and positioning. - Adequate nutrition and fluid intake. Any other task that the HHA may choose to have the home health aide perform. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse. This STANDARD is not met as evidenced by: Based on the agency's Home Health Aide (HHA) training program review and interview, the agency failed to keep track of classroom material, safe techniques in personal hygiene, and supervised practical training hours with the potential to affect all the patients of the agency receiving home health aide services. Findings include: 1. Review of the HHA Training program failed to evidence a record of classroom material, documentation of safe techniques in personal	G 206		

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G 206	Continued From page 7 hygiene, and a tally of supervised practical training hours. 2. On 8/21/13 at 5:09 PM, employee K, Alternate Administrator, indicated the agency did not have a system for tracking classroom material, safe techniques in personal hygiene, or supervised practical training hours.	G 206		
G 210	484.36(a)(3) HHA TRAINING - DOCUMENTATION The HHA must maintain sufficient documentation to demonstrate that the requirements of this standard are met. This STANDARD is not met as evidenced by: Based on the agency's Home Health Aide (HHA) training program review and interview, the agency failed to maintain sufficient documentation to demonstrate that the requirements of the HHA training were met with the potential to affect all the patients of the agency receiving home health aide services. Findings include: 1. Review of the HHA Training program failed to evidence sufficient documentation to demonstrate that the requirements of the HHA training were met. 2. On 8/21/13 at 5:09 PM, employee K, Alternate Administrator, indicated the agency did not have documentation to demonstrate the requirements of the HHA training were met.	G 210		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE	G 225		

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G 225	Continued From page 8 The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the home health agency failed to ensure the Home Health Aide (HHA) followed the HHA plan of care in 3 of 6 records reviewed of patients that were receiving HHA services. (#1, #3, #6) The findings include: 1. Clinical record #1, start of care 3/26/13, included a "Home Care Aide Care Plan / Assignment Daily Visit" with orders for the HHA to make the bed. The "Aide Weekly Visit Record" evidenced the HHA did not document the bed was made for visits from 7/23/13 to 8/16/13. There was no documentation the patient refused to have their bed made. During an interview on 8/22/13 at 5:40 PM, Employee K, Alternate Administrator, acknowledged that the HHA needed to chart make bed or the patient refusal for each visit. 2. Clinical record #3, start of care 3/26/13, included a "Home Care Aide Care Plan / Assignment Daily Visit" with orders for the HHA to provide basic hygiene care. The "Aide Weekly Visit Record" evidenced the HHA charted "Check Pressure Areas" for visits from 7/21/13 to 8/15/13. The "Home Care Aide Care Plan / Assignment Daily Visit" did not have "Check Pressure Areas"	G 225		

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G 225	Continued From page 9 assigned for the HHA to perform. During an interview on 8/23/13 at 5:43 PM, Employee K, Alternate Administrator, indicated the HHA should not have charted "Check Pressure Areas." 3. Clinical record #6, start of care 5/13/13, included a "Home Care Aide Care Plan / Assignment Daily Visit" with orders for "Ambulation: Cane." The "Aide Weekly Visit Record" evidenced the HHA charted "Assist with Ambulation" from 7/8/13 to 8/16/13. The record failed to evidence the HHA charted "Cane" under "Assist with Ambulation." During an interview on 8/23/13 at 5:47 PM, Employee K, Alternate Administrator, indicated that "Cane" or refusal needed documented for each HHA visit.	G 225		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on policy review, clinical record review, and interview, the agency failed to ensure the medication profile was updated and accurate when there were medication changes in 3 of 10 clinical records reviewed with the potential to affect all patients at this agency. (#1, #8, #10)	G 337		

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G 337	Continued From page 10 Findings include: 1. The policy titled "Medication Worksheet & Schedule" policy number CLN.022 undated states,"On re-certification, the nurse must update the Medication Sheet with appropriate changes, sign, and date." 2. Clinical record #1, start of care (SOC) 3/26/13, included a Home Health Certification and Plan of Care for the certification period from 7/24/13 to 9/21/13. The clinical record evidenced a document titled "Communication Note" dated 8/13/13 that indicated the MD discontinued Celexa. The "Medication Profile" evidenced Paroxetine was discontinued on 8/13/13. The Medication Profile failed to evidence Celexa as a prescribed medication. On 8/22/13 at 6:20 PM, employee K, Alternate Administrator, indicated the patient was not on Celexa. Employee K further indicated that they accidentally wrote Celexa when they meant to write Paroxetine. 3. Clinical record #8, SOC 5/8/13, included a Home Health Certification and Plan of Care for the certification period from 7/7/13 to 9/4/13. The clinical record evidenced a document titled "Medication Profile" was reviewed and signed by Employee K, Alternate Administrator, on 5/8/13. The Medication Profile failed to evidence a RN review and signature for the next certification period. On 8/23/13 at 5:02 PM, employee K, Alternate Administrator, indicated the Medication Profile was not signed by a RN for the next certification period.	G 337		

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G 337	Continued From page 11 4. Clinical record #10, SOC 3/28/13, included a Home Health Certification and Plan of Care for the certification period from 7/26/13 to 9/23/13. The clinical record evidenced a document titled "Medication Profile" was reviewed and signed by Employee K, Alternate Administrator, on 5/27/13 and 7/25/13. The Medication Profile failed to evidence a RN review and signature for the SOC on 3/28/13. On 8/23/13 at 5:07 PM, employee K, Alternate Administrator, indicated the Medication Profile was not reviewed or signed by a RN for SOC on 3/28/13.	G 337		